

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-039804

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5331 STATE FILE NUMBER 39804

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY Jackson	a. STATE Mo	b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City	Length of stay in 1b 59 yrs	c. CITY OR TOWN Kansas City	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. General Hosp.	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 315 Highland	If outside, give location Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First Helen	Middle Pauline	Last Bryson	Month 9	Day 29	Year 1963
5. SEX Fe	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/28/1904	9. AGE (last birthday) 59	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursekeeper
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursekeeper			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Kansas City, Mo	12. CITIZEN OF WHAT COUNTRY U.S.
13a. FATHER'S NAME Harvey E. Rider		13b. MOTHER'S MAIDEN NAME Leona Logan		14. NAME OF HUSBAND OR WIFE Thomas Bryson	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	17. INFORMANT Margaret Mc Knight K.C. Mo
---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a) Coronary Occlusion	DUE TO (b) Arteriosclerotic Heart Disease	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	---

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION		COUNTY STATE

21. I attended the deceased from _____, to _____ and last saw her alive on _____
Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Hugh H. Owens (Degree or title)	22b. ADDRESS 152 Union Station	22c. DATE SIGNED 10-28-63
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/2/1963	23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah
23d. LOCATION (City, town, or county) Kansas City, Mo.	24. FUNERAL DIRECTOR C.N. Blackman & Son K.C. Mo	25. DATE RECD. BY LOCAL REG. 10-2-63
26. REGISTRAR'S SIGNATURE Beasie Smith		

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED	INSTEAD OF	DOCUMENT
VS 300 Rev. 4/59		
1		
2 3/108		
3		
4 1		
5 3		
6		
7 0		
8 2		
9 4/200		
10		
11		
12 92-3		
13		

DOCUMENT

BY AFFIDAVIT OF Hugh H. Owens

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN handwriting**.
If this body is not embalmed, fact should be so stated above.